## Appendix 2 **Completed Sample HCFA 1500 Claim Form**

											API	HOVEL	OMB-0938-0008
PICA							HEALTH INS	SURANCE	CI A	IM F	ORM		PICA T
MEDICARE MEDIC	AID CHA	AMPUS		CHAMPVA	GRO	UP · F	ECA OTHER	1a. INSURED'S I			OTTO	(FOR P	ROGRAM IN ITEM 1)
(Medicare #) p (Medica	id #) (Spc	onsor's S	SN)	(VA File #	) HEAL	TH PLAN B	(SSN) (ID)	123	345678	890			
PATIENT'S NAME (Last Na		Middle I	nitial)		3. PATIENT'S	S BIRTH DATE	SEX	4. INSURED'S N			First Name	, Middle	Initial)
Recipient, Im PATIENT'S ADDRESS (No.	A				<u>MM¦D</u>	<u> </u>	4 F X						
oatient's address (No 5 <b>09 Willow St.</b>	Street)					RELATIONSHIP		7. INSURED'S AL	DRESS	(No., Str	reet)		
Y IIIOW St.				STATE	8. PATIENT:	Spouse Ch	ild Other	CITY					STATE
		WI	Single	Married	Other	····							
CODE	TELEPHON	NE (Inclu	de Area (	Code)				ZIP CODE			TELEPHO	NE (INC	LUDE AREA CODE)
55555 (XXX)XXX-XX			X-XX	XXX Employed Full-Ti			Part-Time Student						
THER INSURED'S NAME	(Last Name, Fir	st Name	, Middle I	nitial)	10. IS PATIE		ON RELATED TO:	11. INSURED'S F	OLICY G	ROUP	OR FECA N	IUMBEF	}
OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS)			a. INSURED'S DATE OF BIRTH SEX					
OTHER INSURED'S DATE OF BIRTH SEX					b. AUTO AC	YES CIDENT?	NO PLACE (State)	b. EMPLOYER'S	NAME O	R SCHO		<u> </u>	. [
IM DD YY	J M F	) 	F	, l		YES	NO						
EMPLOYER'S NAME OR SCHOOL NAME				1	c. OTHER ACCIDENT?			c. INSURANCE PLAN NAME OR PROGRAM NAME					
					YES NO								
NSURANCE PLAN NAME	R PROGRAM	NAME			10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
							YES NO If yes, return to and complete item 9 a-d.						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary							INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for						
to process this claim. I also below.								services desc	ribed bela	w.			,
SIGNED					DA	TE.		SIGNED					
	ILLNESS (First	symptor	n) OR	15. [	PATIENT H	AS HAD SAME O	OR SIMILAR ILLNESS.		ENT UNA	BLE TO	WORK IN	CURRE	NT OCCUPATION
I4. DATE OF CURRENT: A ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION  MM DD YY  FROM TO TO					
					17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES  MM DD YY FROM TO TO					
RESERVED FOR LOCAL	JSE							20. OUTSIDE LA	В?		\$ CH.	ARGES	
· · · · · · · · · · · · · · · · · · ·							*	YES	□ NO				
DIAGNOSIS OR NATURE	OF ILLNESS OF	R INJUR	Y. (RELA	ATE ITEMS 1,	2,3 OR 4 TO	ITEM 24E BY LI	NE)	22. MEDICAID RI CODE	ESUBMIS	SION	DRIGINAL	REF. NO	),
1. <u>V23.9</u>							•	23. PRIOR AUTHORIZATION NUMBER					
								23. FRIOR AUTH	ORIZATI	ON NOR	MDEN		
Α		В	С	4.		_	¬ ∈	F		G T	н	Т	K
DATE(S) OF SERV	ICE <sub>To</sub>	Place				S, OR SUPPLIE	S DIAGNOSIS		DA	AYS EP	SDT	605	RESERVED FOR
M DD YY MM		Service	Service	CPT/HCPC	S   MOE	DIFIER	CODE	\$ CHARGES			lan EMG	СОВ	LOCAL USE
15   99	<u> </u>	3	9	W709	90   09		1	XX	XX	1			
15   99		3	9	W709	91		1	XX	XX	1			
20 99	· ·	4	9	W709	92		1	XX	XX	0.8			
1   20   99	Tr	3	9	W709	94		1	XX	XX	1.2			
2 10 99	i	3	9	W709	94		1	XX	XX	0.5			
2   28   99	1.	4	9	W709	02		1	XX	XX	1			
FEDERAL TAX I.D. NUMB	ER SSN	EIN	1	PATIENT'S A		27. ACC	EPT ASSIGNMENT? ovt. claims, see back)	28. TOTAL CHAP		29. 4	MOUNT P	AID	30. BALANCE DUE
				23JED		YE	S NO		X XX	\$		<u></u>	\$ XX.X
SIGNATURE OF PHYSICI, INCLUDING DEGREES OF						FACILITY WHER	RE SERVICES WERE	33. PHYSICIAN'S & PHONE #	, SUPPLI	ER'S BI	LLING NAM	IE, ADD	RESS, ZIP CODE
(I certify that the statement apply to this bill and are ma	s on the reverse					,		I.M. Bi	lling				
	a part thoret							1 W. W		18			
	N. JE / TO TO 18 78 7	7											
M. Authorized M	M/DD/YY DATE							Anytov			555	876	54321